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THE SOCIAL AND HISTORICAL CONTEXT OF THE PROFESSION

Like all professions, clinical psychology has both features that it shares with other professions and characteristics that are peculiar to itself. In this introductory chapter we will first examine the nature of professions, drawing heavily on their sociology. This summary of sociological approaches to professional life should assist the reader to understand how clinical psychology reflects and reproduces general features of what came to be known during the twentieth century as the 'new middle class' (Carchedi, 1977). After this general sociological introduction we will identify one aspect of the particular character of British clinical psychology: its *history*. This history reflects the contested *knowledge base* of the profession – a subject we will return to in Chapter 2. In Chapter 6 we revisit this discussion by examining the ways in which this knowledge is expressed in British clinical psychology, both organisationally and rhetorically, as a form of *clinical expertise*. Our final chapter incorporates further discussion of the profession's internal dynamics and socio-political context and suggests how these factors are shaping its future.

What are professions?

The reader of this book, and of others in the series, can appraise the socio-political character of particular professions on a continuum from hostile scepticism to naïve trust. The former can be summarised in George Bernard Shaw's suggestion that 'the professions are a conspiracy against the laity'. This expression of outright distrust of self-serving professionals is also found in the sociology of the professions, as is its opposite: the view that professions are benign, altruistic and productive contributors to modern societies. In order to make sense of this range of views, and their potential applicability to clinical psychology, we will provide a summary of some sociological work about the mental health professions.

The mental health focus may seem overly restrictive, given that today clinical psychologists work in a variety of settings. However,

the roots of the profession lie mainly in mental health work. Furthermore, in other clinical settings such as learning disability, child and adolescent services and physical health care, the profession finds itself, competitively or co-operatively, working alongside psychiatrists and other mental health professionals. Finally, the activities clinical psychologists are involved with in all health service contexts aim to improve well-being and quality of life, ameliorate distress, and reduce or control dysfunction. Taken together, these aims constitute mental health work in a very broad sense.

Clinical psychology is part of what poststructuralist sociologists call 'the psy complex' (Rose, 1985). Here the word 'complex' refers to a complex of professions (psychiatry, psychiatric social work, mental health nursing, counselling and psychotherapy) in interaction, with a variety of overlapping practices. The boundaries within this complex are murky, as we will show. Consequently, many of the issues considered in this text, although primarily focused on clinical psychology, necessarily address the psy complex in its totality.

Sociological accounts of modern professions

We noted above that views of the general public and of sociologists studying professions form a continuum. Saks (1983) compared sociological accounts of modern professions and identified three main types. The first, derived from the work of Emile Durkheim and Talcott Parsons, emphasised the functions of professions for society and the positive traits expected of, and delivered by, professionals (altruism, integrity, efficiency, unique skills, trustworthiness). This conservative trait and function approach no longer finds much favour within sociology, although professionals themselves may offer such descriptions as part of an exercise in collective self-promotion. Another point about this approach is that the very word 'professional' has entered the vernacular. It has come to mean efficient and trustworthy expertise. While sociologists have developed critical perspectives on the professions, our everyday discourse about them may still imply positive personal and social features.

The second approach to the professions suggested by Saks (1983) is derived from the work of Max Weber and remains the one most critical of the professions (more so than a Marxian approach: see p. 3 below). The neo-Weberian analysis of professions suggests that they act to exclude competitors in the market place and subordinate or dominate both their target client group and less-developed

professions working in their field. Two notions in particular capture these processes: social closure and professional dominance.

Social closure entails professional groups advancing their interests in society by controlling their recruitment and excluding competitors. By these means they justify the maintenance and extension of both their economic value (fee or salary) and their social status and influence, by successfully convincing their employers and clientele that they possess unique expertise. This activity of closure entails professions regulating their own boundaries. Thus, entrance to a profession requires the acquisition of credentials and successful employment in a particular role. Those without this accredited and employed status are denied access to both privileged knowledge and forms of legitimate action, whether they are other workers or the profession's clients.

Professional dominance means that professionals try to acquire and maintain a dominant position in relation to others in society. This takes three forms. First, professionals have power over their clients, who are less knowledgeable and therefore may depend on professional expertise. Second, they have power over aspiring colleagues – applicants for training and those recently qualified. Third, they may acquire power over other professionals who have weaker claims to legitimacy because, for example, these latter professionals' knowledge base is less exclusive, their training is shorter or they lack formal legal powers (such as the power to detain a patient under the Mental Health Act). In particular, dominant professions will resist encroachment from other groups, whilst the latter will endeavour to encroach on work dominated by older professions or make bids for the legitimacy of new work.

A third sociological approach to the professions is that of the Marxian tradition. This approach has generated contradictory interpretations. Marxists can be found arguing that the professions constitute a part of the ruling class (Navarro, 1986); that they are part of the working class (the 'proletarianization' thesis: Oppenheimer, 1975); or that they constitute a new class in between the proletariat and the bourgeoisie. This last view of professionals, as a contradictory social group, has been argued by Carchedi (1977) and Johnson (1979). In their view the professions serve the interest of capital by forming a regulatory apparatus to maintain social stability in a capitalist society. However, when they are state employees (for example, in health and education) they are subject to bureaucratic subordination, which erodes their social power, making them wage slaves like any other worker.

Since Saks offered his overview of the sociology of the professions in the early 1980s, sociology has been influenced significantly by

poststructuralism – especially the work of Michel Foucault. A fourth sociological position has emerged, arguing that power is dispersed and is not possessed clearly by one social group in relation to another (as suggested in different ways by Marx and Weber). Instead, the poststructuralists argue that power takes the form of discursive practices or discourses, which are precarious and can be challenged. At the same time, in their orthodox dominant forms, professionals and clients alike can share and be trapped in a particular set of practices and ways of framing reality. For example, professionals may have preferred ways of conceptualising and practising their work. Their current and potential clients can accept, ignore or resist this authority. Similarly, some in a profession may conform to an orthodox approach, while others may construct an alternative view.

A fifth current within recent sociological debates has been feminism, which at times has overlapped with Weberian, Marxian and poststructuralist accounts (Crompton, 1987; Pollert, 1996). The central organising concept is that of patriarchy, according to which some or all social divisions are accounted for by the political struggle between men and women, with the former dominating and the latter resisting. When this frame of analysis is applied to professional life a number of topics recur, including barriers to female entrants; obstacles to career advancement for women within professions; gendered divisions of labour within and between professional groups; the lower status and earning power of female-majority professions; and the experience of women as workers and mothers (Davies, 1996). Davies argues that the central issue for women is not their exclusion from the professions but the gendered way in which they are *included*. Another topic that has emerged within feminist debates about the professions is the gendered nature of professional knowledge, a point we return to in Chapter 6.

The applicability of sociologies of the professions to mental health work

We now turn to the relevance or ‘fit’ of different sociological approaches to the professions when mental health work is studied. We will focus on clinical psychology but allude at times to other professions. To focus on clinical psychology alone might mislead the reader by giving the impression that only this profession needs to be analysed critically; and the activity of clinical psychologists, like that

of other professionals, occurs in an inter-professional context, especially in health care bureaucracies. Clinical psychology cannot be understood in isolation.

We mentioned that the trait and function approach has fallen from favour within sociology. This approach, elaborated by Parsons, embraced the preferred accounts offered by professionals (especially professional leaders) and contemporary examples can be found in standard introductory texts about clinical psychology. One such 'public relations' view is provided in a recent account of the profession by two of its senior members:

In summary, clinical psychologists are psychologist-practitioners applying scientific knowledge and principles in a professional role to the alleviation of human suffering and the improvement of the quality of life.

(Marzillier and Hall, 1999: 9; italics in the original)

This view is the bread and butter of professional leaders' negotiations with employers and politicians. For example, when the Division of Clinical Psychology or the Professional Affairs Board of the BPS is asked to the negotiating table with civil servants, or its written comments on legislative or organisational change in the NHS are requested, it will take the opportunity to promote the interests of psychologists by stressing their special skills.

This activity is predicted most emphatically by the neo-Weberian approach to the professions, which suggests that they are perennially in the business of boundary maintenance, the making of new bids for legitimacy and the exploitation of opportunities for social advancement. Shaw was probably wrong to suggest that this happens conspiratorially *between* the professions, because they are frequently in competition with one another. For example, the activities of mental health nurses and of psychiatric social workers overlap. This creates the risk of one group substituting for the other (Rogers and Pilgrim, 2001). Clinical psychologists face a similar risk when they retain a therapist-only role in their work since those trained in psychological therapies from other professions, such as mental health nursing, can also fill that role. In order to counteract this threat, leaders of the profession have argued that psychologists employ unique skills within the therapist role (Parry, 1989; Hallam et al., 1989). In the 1980s, when the role of psychologists in the NHS was examined by government, boundary maintenance was negotiated successfully by leaders arguing that clinical psychologists alone have 'level 3' therapy skills (see, p. 18 below).

Clinical psychology is one of the highest-salaried non-medical professions and yet it is predominantly a female profession.

Concerns about women undermining the social status and salary levels of clinical psychology have been publicly expressed by some men (Crawford, 1989; Radford and Holdstock, 1995). The point made by Davies about the peculiar ways in which women are included in the profession is relevant here. Although the majority of the profession is female, men are over-represented in senior management roles (Murray and McKenzie, 1998).

As we noted in the introduction to this chapter, generalisations in the sociological literature on the professions beg particular questions about individual professions. In the present discussion this prompts us to acquaint the reader with relevant details from the history of British clinical psychology.

A short history of British clinical psychology

In the early days of British clinical psychology, one of its professional leaders, Hans Eysenck, noted that 'psychology has a long past, but a short history' (Eysenck, 1953: 22). In this book we will explore the meaning of this claim. Clinical psychology is one of several specialist applications based upon what is now the single academic discipline of psychology. However, while psychology is typically organised in dedicated university departments, its theoretical and empirical concerns overlap with those of its neighbours, such as philosophy, other human sciences (e.g. anthropology and sociology) and the biological sciences (e.g. physiology and neurology). To understand this connection to other academic disciplines, clinical psychology's 'prehistory', as well as its history, needs to be examined. In this chapter we will first deal with the period just prior to the profession's formation in the 1950s and then with its development after that time. Finally, some points will be made regarding North American influences on the development of clinical psychology in Britain.

Academic psychology becomes established in Britain

By the end of the nineteenth century it was becoming evident that the discipline of psychology was about to differentiate itself from philosophy. This first took place in Germany, with other countries such as Britain and the USA catching up within a few decades. The earlier developments in Germany meant that the German model of experimental work was influential for a while across both the Atlantic and the English Channel, with pioneers such as Weber, Fechner, Helmholtz, Lotze and Müller first defining the academic field.

In Britain, the work of Francis Galton (Darwin's cousin) and the social movement of eugenics ensured that an evolutionary perspective would become important in both British psychology and psychiatry. Its specific impact on later clinical work derived from the notion that innate individual differences between people could be measured – the beginnings of the psychometric measurement of intelligence and personality that became known as differential psychology. This hereditarian focus was at odds with the older empiricist tradition in Britain, and subsequent developments (for example in Eysenck's methodological behaviourism) reflected a principled acceptance of the variable interaction between genes and learning. Methodological considerations in this nascent period emphasised experimentalism, psychometrics, the hypothetico-deductive method and the use of statistical methods to map populations and define experimental and control groups.

In the academy, the differentiation from philosophy was slow, with leaders of the parent discipline retarding the independence of psychology. By the outbreak of the Second World War, there were still only six chairs in psychology in the British academic system (Hearnshaw, 1964), despite the emergence of a dedicated professional organisation at the turn of the century. The Psychological Society was inaugurated at University College, London, in 1901, taking the term 'British' in 1906 to become what is still called the British Psychological Society (BPS). In 1902 its membership was a mere 13 and the BPS remained a tiny club of philosophers and psychologically minded medical practitioners until the First World War (Edgell, 1961).

Soon after the BPS was founded, the *British Journal of Psychology* was also set up (although this was, to begin with, separate from the Society). In the very first statement from the founding editors, James Ward and W.H.R. Rivers, the remit of the new discipline was announced:

Psychology, which till recently was known among us chiefly as mental philosophy and was widely concerned with problems of a more or less speculative and transcendental character, has now at length achieved the position of a positive science; one of special interest to the philosopher no doubt, but still independent of his control, possessing its own methods, its own specific problems and a distinct standpoint altogether its own. 'Ideas' in the philosophical sense do not fall within its scope; its inquiries are restricted entirely to facts. (Editorial, *British Journal of Psychology*, 1904, 1 (1): 1)

Given the slow organisational separation of psychology from philosophy in the academy during the first quarter of the twentieth century, Ward and Rivers were being rhetorical rather than accurately

descriptive. Indeed, they were setting out the stall for the new academic discipline and their emphasis upon the pursuit of ‘facts’, together with their insistence on psychology being a ‘positive science’, is therefore important. The central orthodoxy in British psychology was and still is positivistic, although philosophical idealism has been a constant thorn in its flesh (most recently this has been evident in the emergence of postmodernism within academic psychology). Psychology made its initial claim for separate legitimacy by emphasising objectivity and empiricism as the features that distinguished it from philosophy, which was preoccupied with metaphysics and logic. While philosophy was a cerebral activity, relying on speculation, introspection and reflection, psychologists had begun to test experimental hypotheses and devise practical interventions based on emerging theories.

Developments in the USA followed a similar pattern although the differentiation of psychology from philosophy occurred slightly earlier and was driven by members of both disciplines. For example, in their textbooks at the end of the nineteenth century both William James and John Dewey explored the need to shift from philosophy to psychology, while recognising the debt owed to the former by the latter (James, 1890; Dewey, 1886). It is significant that although Dewey was a philosopher, he championed pragmatism in his discipline. The special relationship between Britain and its ex-colony has led to an identifiable form of Anglo-American psychology over the past century, but British developments have generally tended to follow trends originating in the USA.

Popular and professional psychology in Britain 1900–50

Although the emancipation of psychology from philosophy, marked by the founding of the Psychological Society in 1901, was essential for its emergence as an independent discipline, Thomson (2001) argues that the subsequent development of British academic and professional psychology can only be fully understood by charting their evolving relationships with popular psychology during the first half of the twentieth century. In the following section we will summarise some of the main points contained in Thomson’s informative account of this relationship.

While the organised discipline of psychology was still in its infancy, a vigorous self-help culture with its origins in nineteenth-century movements like phrenology was flourishing in Britain. Popular psychology then, as now, was pluralist and maintained a strained relationship with the medical profession. In the same year

that the British Psychological Society was formed, the London Psycho-Therapeutic Society was established as an ecumenical forum to promote the 'psychic' interests of Spiritualists, Theosophists, the Mental Science, Christian Science and Divine Science Movements. The Society's members were not only committed to investigating psychic forces, but also wished to apply them therapeutically – hence the antagonism of the medical establishment. As the century unfolded, the Society increasingly sought to distance itself from the religious movements it had encompassed through its membership by reinterpreting psychic power as a manifestation of 'natural law': the health of the mind and body now became acknowledged goals, instead of spiritual health alone.

The psychotherapeutic emphasis of the Society was initially influenced by continental psychology's interest in hypnotism and suggestion, while psycho-magnetics and mesmerism also featured in the treatments offered by its members. However, influential popular writers like Emile Coué, C. Harry Brooks and Dr Bernard Hollander, Britain's leading phrenologist and a frequent contributor to the *Psycho-Therapeutic Journal/Health Record*, subsequently led the trend away from reliance on experts to cure society's ills. Instead, these authors encouraged people to harness their own healing power through healthy living, self-control and auto-suggestion. Coué, for example, exhorted the use of positive affirmations to promote mental health in his widely read self-help manual: *Self Mastery through Conscious Autosuggestion* (1922).

By the 1920s this interest in self-help had produced a new front in the lay psychology movement and its members identified themselves as practical psychologists. The Federation of Practical Psychology Clubs of Great Britain emerged, with its own journal: *Practical Psychologist*. By the end of the 1930s there were over 50 clubs throughout England and Scotland, coexisting with smaller lay psychology movements and unaffiliated individuals pursuing their own psychological studies and enquiries. Thomson suggests that the vigour of these popular movements is understandable because they met a number of societal needs, including a demand for psychological therapy that the medical professionals were unable to deal with.

One of the important features of Practical Psychology was that it professed to be scientific in its approach to self-improvement. Its founder, Anna Maud Hallam, described its approach in the inaugural edition of *Practical Psychologist*:

PRACTICAL psychology is a scientific effort to unfold and understand the laws operating in human life....This great study of human life brings new enlightenment,

new education, new and clearer understanding of the phenomena of every-day life. It is an effort based upon unbiased investigation, research, experiment and observation, with just one motive underlying it – to assist the individual in knowing himself. (Hallam, 1925: 1)

Thus, the Practical Psychologists set out their stall by claiming intellectual rigour and scientific credibility. The distinction they drew between their own work and that of the academic psychologists was merely one of orientation:

Academic psychology will centre the cause of these mental conflicts in the various human instincts. The student of practical psychology will explain them under the caption of the subconscious mind where all instincts, emotions and inclinations have their origin. (Hallam, 1925: 2)

While asserting its scientific credentials, Practical Psychology retained a spiritual dimension. Its goal was personal enlightenment, and it couched this in language that appealed to both humanists and committed Christians. The movement thus ensured itself a substantial following.

From its initially competitive position in relation to academic psychology, Practical Psychology adopted a less combative stance during successive years. As medically qualified psychotherapists joined the fray, Practical Psychology increasingly assumed the role of ‘populist intermediary’ (Thomson, 2001) between the professionals and the public. By the end of the 1930s, Practical Psychologists had begun to write self-help manuals focusing on problems identified by academics and professional psychologists (such as inferiority complexes and nervous tension), instead of guides to self-enlightenment.

As Thomson points out, the influence between professional and lay psychology was not unidirectional. The popularisation of psychology appeared immensely threatening to professional psychologists who were insecure about the scientific foundations of their young discipline, and they initially fought back by attacking the unscientific nature of the popular treatises. However, as the century progressed, some members of the profession began to recognise the potential of popular psychology to extend the influence of the discipline and some of them, like Cyril Burt, began to write (and even broadcast) with a wider audience than the academic community in mind. The boundary work of these psychologists involved educating the public about matters psychological in a way that would convince them that psychology was scientific and sufficiently complex to merit the employment of experts as disseminators of this knowledge. The British mental hygiene movement represents a more co-ordinated attempt by the professionals to popularise psychological theory in

order to advise the public on how to lead a psychologically healthy life. Thomson suggests that this movement's limited success was at least partly due to the profession's ambivalence about the extent to which they were prepared to give psychology away.

Thomson's account of the relationship between professional psychologists and these popular movements in the first half of the twentieth century is relevant to our discussion for several reasons. First, it provides a counterbalance to the poststructuralist view of psychology during this period as a conservative if not oppressive force dedicated to social adjustment. Second, it demonstrates the falsity of the view that popular psychology is a recent product of professional psychology, and essentially a watered-down version of the latter. Instead, it describes the origins of what we now term the users' movement and shows that the profession has had to engage in boundary work throughout its existence – not only with other professions (psychiatry, in particular) and other disciplines (such as medicine and science), but also with the general public. Finally, Thomson argues that the popular psychology movement arose to meet a demand that was not being met by academic psychologists or the medically qualified therapists of the period.

Jones and Elcock (2001) have suggested that 'disciplinary psychology' is still failing to meet the public demand for what they term 'everyday psychology': the psychologising we all do, all the time, in order to make sense of our world. They conclude that 'scientific psychology' needs to make renewed efforts to be relevant to this, to be accessible while retaining theoretical and evidential rigour, in order to contribute to a shared, informed view of the world. We will consider these issues in greater detail in the next chapter.

The emergence of clinical psychology in Britain

The major historical roots of British clinical psychology can be traced to events surrounding the First and Second World Wars. Dominant forms of psychology that had emerged from the academy (psychoanalysis, differential psychology and learning theory) were challenged and influenced in the context of war and post-war conditions between 1914 and 1950. After 1914 the problem of shell-shock, or war neurosis, was an important spur for developing psychological formulations and treatments (Stone, 1985). The men breaking down in the trenches were 'England's finest blood' and not the 'tainted gene pool' which, it was commonly assumed, had inhabited the asylums and workhouses. The soldier-patients were both officers and gentlemen and squaddie volunteers, with the first

group actually breaking down at a higher rate than the second (Salmon, 1917). In this context, the eugenic bio-determinism favoured by asylum doctors was seen as a sort of treason. Consequently, it fell from favour in government circles, creating a political space for the growth of psychological approaches.

In 1919 the first section of the BPS to be formed was the Medical (now Psychotherapy) Section and it was dominated by doctors returning from their war work, treating victims of shell-shock. In the same year the British Psycho-Analytical Society was established, with an overlapping membership. During the war, increasing interest had been taken in psychosomatic aspects of fatigue, with the focus particularly on the overworked female employees in the munitions factories. The Health of Munitions Workers Committee (later renamed the Industrial Fatigue Board) was set up by Lloyd George in 1915 and was subsumed by the Medical Research Council in 1929. This formed the focus for the early development of industrial psychology in Britain, with Cyril Burt and others beginning to apply psychological methods within the military-industrial complex.

Thus, it was the costly state-endorsed violence of the 'Great War' that was the biggest political spur to the development of applied psychology. The doctors returning from military service contributed to the status and influence of what was to become one of two key training bases for clinical psychology: the Tavistock Clinic. During the 1930s, with another war becoming inevitable, the Ministry of Defence recruited psychologists and psychotherapists to oversee selection procedures in an attempt to filter out emotionally vulnerable military applicants. An indication of the status of the psychoanalytic tradition in this period was that the appointed head of the army psychiatric services in 1939, J.R. Rees, was a psychoanalyst. He had been director of the Tavistock Clinic since 1934.

During the Second World War the role of psychologists and psychotherapists within the military expanded yet further. In addition to recruitment and selection, they were increasingly involved in training, and in the prevention and detection of malingering (Bourke, 2001). The demand for psychological treatment also increased substantially as the new hostilities with Germany saw the return of war neurosis. (During this conflict, 20–50 per cent of all military discharges were the result of psychological trauma: Bourke, 2001.) A variety of hospital settings were utilised to treat what has now become known as 'post-traumatic stress disorder'. In 1942 Hans Eysenck was appointed as a research psychologist at one of these bases: the Mill Hill Emergency Hospital.

When Mill Hill was reconstituted at Camberwell after the war, it formed the basis of the new Institute of Psychiatry with several academic departments that were linked to clinical services in the Maudsley Hospital. Eysenck was appointed as head of psychology at the Institute. The first clinical psychology course, based at the Institute, was limited to the psychometric assessment of patients and emphasised the role of psychologist, not as therapist, but as *applied researcher*. This tension between the healing role with its fluid intersubjective character on one side, and the 'disinterested scientific stance' of the psychological researcher on the other (Eysenck, 1949, 1950), continues to characterise the profession to this day.

The development of British clinical psychology after 1950

Postgraduate clinical psychology training initially developed at three sites in Great Britain – the Tavistock Clinic and the Institute of Psychiatry in London, and the Crichton Royal Hospital in Dumfries, Scotland. In 1957 these became the first three courses to be recognised within the government's Whitley Council negotiating system for the NHS. While the Tavistock tradition, based upon psychoanalysis, was to drive the therapeutic community movement post-war, Eysenck's course would become the dominant influence in the profession. For many years to come, new courses set up throughout Britain (usually, but not always, in the old universities with medical schools) were headed up by Institute/Maudsley graduates.¹ Between 1950 and 1980 the profession developed through three phases (psychometrics, behaviour therapy and eclecticism) that reflected epistemological and professional tensions (Pilgrim and Treacher, 1992).

The *psychometric* phase of British psychology was short-lived (1950–58). At first Hans Eysenck insisted that experimentalism and the psychology of individual differences (in the tradition of University College, London dating back, via Burt and Spearman, to Galton and his eugenic acolytes in the late Victorian period) should characterise the work of clinical psychologists. Intelligence testing and personality assessments looked set to define the new profession in quite narrow terms. Indeed, when Eysenck visited the USA in 1948 to look at clinical psychology programmes, he took his American colleagues to task, arguing that their therapeutic aspirations were at odds with the disinterested stance required by a scientific attitude (Eysenck, 1949, 1950). Eysenck saw therapy as 'essentially alien to clinical psychology' (Eysenck, 1949: 173), a view that survived in the profession long after Eysenck recanted his

position. At the Crichton Royal Hospital, Dumfries, for example, another psychometrician and professional leader, John Raven, continued to argue, during the 1960s, that therapy was outside the legitimate remit of clinical psychology (Hetherington, 1981).

In fact, arguments about whether psychometrics should partially or wholly define the role of clinical psychologists had started in the USA as early as 1913. There, the profession emerged more than thirty years before it did in Britain. By 1917, the short-lived American Association of Clinical Psychologists had been established, to be superseded two years later by the enduring structure of the Clinical Section of the American Psychological Association. By the time Eysenck did his rapid audit-by-visit after the Second World War psychometric assessment was still an important role for clinicians in the USA, but it had been joined by a range of psychotherapeutic activities as well – some based on psychoanalysis and others on behaviourism.

The psychometric phase of British clinical psychology gave way in the late 1950s to *behaviour therapy*, with Eysenck and his colleagues Monte Shapiro and Gwynne-Jones suddenly shifting their focus in a bid to wrest psychiatry's control of the therapeutic jurisdiction of neurosis. This bid was made very publicly in a paper Eysenck presented, with Gwynne-Jones, to the Royal Medico-Psychological Association (since 1971, the Royal College of Psychiatrists) and represented a notable ideological U-turn by Eysenck (Eysenck 1949, 1958). We will reconsider these events in more detail in Chapter 2 when we discuss the genesis of the scientist-practitioner model in British clinical psychology.

The third phase of the profession was one of *eclecticism*. This ensued because clinical psychology failed to develop a firm consensus about its core role. Although an official stance regarding the psychologist as scientist-practitioner had remained predominant in both the American Psychological Association and the BPS since the early 1950s (Raimy, 1953; Shapiro, 1951), it had failed wholly to displace other theoretical strands (particularly variants of phenomenology and psychoanalysis). By the 1970s, pluralism had become commonplace in NHS departments. This was reinforced by the shift in academic psychology from behaviourism to cognitivism, which was paralleled by a (theoretically contradictory) orthodoxy of cognitive-behavioural methods of treatment. Hybrids of cognitivism and depth psychology, such as cognitive-analytic therapy, also emerged. For the past twenty years clinical psychology has retained this eclectic and pluralistic character.

Self-regulation in British clinical psychology: the 1970s and beyond

Until the late 1970s there were few signs of clinical psychologists seeking to advance their status through formal state recognition. Although psychologists disagreed with one another about their role and its content, they all accepted that their academic credentials were sufficient to justify their social legitimacy and employment status. Whilst there had been no proactive interest from the Ministry (now Department) of Health in the post-war years in converting clinical psychology into a registered profession, during the 1970s a number of concerns began to emerge about 'mind-bending techniques'. In the early 1970s, the Church of Scientology had attempted to infiltrate and take over the largest British mental health charity, MIND. This crisis stimulated an official investigation (Foster, 1971) into the role and impact of scientology, which offers a form of psychotherapy called 'dianetics'.

Foster recommended that there should be state registration of psychotherapists but his prompt to government remained unheeded, although private psychoanalytic organisations (i.e. not the BPS) maintained a lobby to support some form of registration. Another report was then commissioned and in 1978 the Seighart Report on the registration of psychotherapists was published, supporting Foster (Seighart, 1978). Once again, these recommendations failed to stimulate government action over new legislation.

Meanwhile, the Trethowan Report on the role of psychologists in the NHS (DHSS, 1977) had given the green light for clinical psychology's formal separation from psychiatry. Since 1958, when clinical psychologists moved presumptuously into the medical territory of treatment, relationships between the two professions had deteriorated. By the mid-1970s clinical psychologists were increasingly resistant to efforts by psychiatric colleagues to maintain leadership in NHS mental health services. As GPs began to refer patients directly to clinical psychologists, the profession no longer had to depend on psychiatrists to provide it with work. Within localities relationships between psychologists and their psychiatric colleagues generally became more distant and, in some instances, openly confrontational.

The Trethowan Report was produced during the 1980s by a sub-committee of the DHSS Standing Mental Health Advisory Committee under the leadership of Professor W.H. Trethowan, and it represented the first major official statement about the organisation and management of clinical psychology services in the NHS. The Secretary of State broadly welcomed its recommendations, while commending to the various health authorities only those

recommendations without financial implications. The BPS also welcomed the Report and it provided the model for organisation of clinical psychology services for the next twenty years – until the introduction of NHS Trusts under the Conservative government began to dismantle service structures that spanned more than one Trust.

The Trethowan Report recommended that services should be organised on an area basis and be provided by area departments of clinical psychology. It did not define what, specifically, it meant by ‘Area Department’, but the implication was that clinical psychologists would no longer be employed by specific hospitals or services, but would be accountable to the employing Health Authority through the Area Department. The report also proposed that these departments should contain a number of specialist sections, with a total of eight sections envisaged for a fully developed area department, namely: physical handicap; mental handicap; child health (child psychiatry and paediatrics); neurological science; mental illness (including forensic psychiatry and psychotherapy); geriatrics; adolescent services; and primary health care. Thus, departments would offer a generic service although individual clinicians would specialise in work with particular client groups. The BPS concluded that area departments had four main advantages: (1) they could allocate their resources as they saw fit to best meet the needs of the population served, rather than being constrained by the individual contractual ties of clinicians to particular hospitals/services; (2) they allowed for both exchange of ideas and enhanced professional support among clinicians, thus reducing professional isolation; (3) they promoted increased efficiency in clinical psychology training (by allowing trainees to move between specialist sections within the same department) and (4) they contributed to higher professional standards (McPherson, 1983). As noted above, the creation of area departments of clinical psychology also shifted the power balance between psychiatry and psychology in the modernising NHS.

The juxtaposition of the Seighart and Trethowan Reports marked a turning point, and increasing efforts at self-determination in the profession ensued. However, after 1979 these efforts were made in the face of growing hostility to professional autonomy on the part of the British government. Margaret Thatcher’s project of (partial) re-commodification of the welfare state was to affect all public sector employees, including clinical psychologists.

In 1979 the Division of Clinical Psychology (DCP) rejected the Seighart recommendation on *psychotherapy* registration but immediately began work on developing a case for government for

the registration of *clinical psychologists* in the UK. The plan to register psychotherapists brought with it the danger of state recognition of a motley group of therapists with their own forms of applied psychological knowledge. In order to ward off this competing bid for legitimacy from those outside the profession, the DCP pushed for registration on its own terms for its own practitioners.

By seeking to operationalise the mandate to practise as an applied psychologist, in terms that coincided with the pre-existing credentials of DCP members, the profession was pursuing a strategy that was doubly advantageous. It would exclude competitors who were not qualified in academic psychology and it would mean that the DCP did not have to define precisely what psychology *was* (except in the circular sense of it being what is taught at a particular time to undergraduates studying psychology). This was important, given the contested nature of psychological knowledge. While some professions like dentistry or surgery can operationalise their knowledge base with a degree of contemporary certainty, this is considerably more difficult in psychology.

Psychological knowledge has always been divided, with incommensurable epistemological strands at its heart (Foucault, 1973; Smart, 1990). Human experience and conduct are complex and thus open to many types of conceptualisation and forms of practical investigation. Phenomenology, experimentalism, differential psychology, behaviourism, psychoanalysis, cognitivism and, latterly, social constructionism have jostled for position and ebbed and flowed in fashion, in undergraduate studies and postgraduate training. All have had their devotees, and factionalism has been guaranteed.

In this context it would be nigh impossible for the BPS, at any point in time, to offer to government for serious consideration a coherent *definition*, let alone a coherent body of knowledge, which summarised the agreed content of the academic discipline of psychology, or the scope of work of its professional wings (such as the DCP). Emergent qualities which psychology graduates may possess, as a result of the contested terrain of their discipline, are a tolerance of uncertainty and a tendency to examine knowledge claims sceptically. However, these laudable intellectual virtues have not been overly-emphasised by the profession, when it has pleaded to government for privileged recognition.

In the 1980s a phase of *managerialism* succeeded the earlier focus on irresolvable epistemological tensions within the profession (Pilgrim, 1990). The term 'managerialism' had a double significance during that time. Not only did the profession set out more formally to establish the conditions of self-management but it also had to adapt

to a central government policy of imposed general management. The campaign for registration in the 1980s was driven initially by the DCP but very soon the wider leadership within the BPS took up the cause. Between 1984 and 1988 the sheer volume of work required to advance the cause of registration and adapt to the demands of general management in the NHS meant that the DCP had to appoint a full-time employee to manage this bureaucratic complexity.

The more mature profession of medicine reacted pugnaciously during this period to the pressures caused by the bureaucratic subordination being imposed by Thatcher's government. The smaller and less secure profession of clinical psychology proceeded more cautiously. Some psychologists (like many nurses) secured posts as general managers. The profession's leadership agreed to a review by the Manpower Advisory Group (MPAG) of the Department of Health. This was a controversial move, with a vociferous minority in the profession making a failed bid for a vote of no confidence in the leadership. The internal critics argued that, given Thatcher's hostility to the health professions, the time was not right to bare a collective throat.

The manpower review was relevant to the chances of professional advancement in an unpredictable way. Published in 1988, it had no catastrophic effect on the profession but gave little clear indication of how its positive recommendations might be applied within an NHS structure, which was being rapidly fragmented by quasi-marketisation. The main advantage of the review to the profession was not that it justified the employment of a certain number of psychologists in the NHS but it provided a focus for its identity. A leading clinical psychologist and member of the MPAG made the point that:

The 1980s has been about establishing who we are, what we can do and what is our core identity. If you like it is has been about establishing a proper rhetoric of justification. The hostile climate for professionals has put pressure on us to clarify and justify what we are about. (Parry, 1990, cited in Pilgrim, 1990)

As it turned out, Derek Mowbray, the consultant employed by the MPAG to review the state of clinical psychology, created an opportunity for it to make a claim of uniqueness. He argued that the broad-based higher education in psychological knowledge that clinical psychologists enjoyed put them in a special position to offer skills to the NHS. Mowbray's argument was that psychological skills could be divided into three levels. Level 1 skills are used to establish rapport or conduct simple interventions like stress management. Level 2 skills are used in more complex interventions, but are reducible to manual-based techniques that can be followed like recipes. Level 3 skills, however, are required when therapists offer

unique psychological formulations and interventions in particular person–situation contexts. Mowbray proffered the view that only clinical psychology could offer level 3 skills, with levels 1 and 2 being offered by other health workers.

Thus, by 1990, clinical psychology had an official report arguing for the profession's unique skills and it had secured the right to keep its own register of qualified practitioners. It had not managed to ensure mandatory registration of its membership, although the leadership of the profession has maintained a campaign for this to the present time, and it is now imminent (see Chapter 7). Meanwhile, the discourse about the registration of psychotherapists has also continued. After many years of internecine disputes and tentative alliances between therapists with a vast array of training backgrounds, the United Kingdom Council for Psychotherapy was set up in 1993. Since then the UKCP has pressed for the registration of its members. However, at the time of writing, there remains no legal requirement for psychotherapists to be registered.

During most of the 1990s the profession pursued new forms of legitimacy. In the early 1990s a three-year doctoral programme replaced the two-year master's programmes in clinical psychology as the required professional training. A form of mimicry of medicine had already begun in the 1980s, with some members of the most senior ('Top') grade in the profession adopting the new title of 'Consultant'. The adoption of the title of 'Dr' by all new entrants to clinical psychology completed the emulation of the profession that had previously subordinated the work of psychologists. As medical practitioners generally do not hold a doctorate, and so claim 'Dr' as an honorary prefix, psychologists, and latterly pharmacists, are now arguably 'out-doctoring' the medics. Today, the salary levels of clinical psychologists remain below those of medical practitioners, but not by much. In many ways clinical psychologists have accrued the very trappings of a profession that was previously a source of resented constraint. One observer has suggested that, during the 1970s, clinical psychologists began a campaign not only of escape from medical domination, but also of incremental emulation and reactive encroachment (Clare, 1979).

Discussion: the influence of the past on the present

This chapter has outlined sociological debates and has highlighted some key historical influences on the development of clinical psychology in Britain. Some general summary points can be made here:

- Our main concern in this book is to provide an account of clinical psychology from a British perspective. Empiricism has had a profound influence within our culture. Its historical power is evident internationally but its enduring native influence is also significant. For example, psychoanalysis was an interloper in British culture and, as a consequence, it has either been derided in British clinical psychology (a position championed by Hans Eysenck in the 1950s) or contained on the exotic margins of private practice and medical psychotherapy. By contrast, psychometrics, behaviour therapy and cognitive-behaviour therapy, with their roots in the work of Galton, Locke and Hartley, are British in character and so rest comfortably within our cultural orthodoxy. British clinical psychology is certainly pluralistic but there remains a core orthodoxy of psychometrics and elaborated methodological behaviourism – first behaviour therapy and now cognitive-behaviour therapy. This core orthodoxy largely defines the taught curriculum for British clinical psychology trainees.
- Despite the virtual separation of philosophy from medicine until the nineteenth century, psychiatry became an important force in shaping the character of clinical psychology. It seems that clinical psychology can neither live happily with psychiatry nor without it. Once *clinical* psychology was established as a profession (beyond being part of an academic discipline of psychology) it began to behave like other professions. It defined its boundaries and made bids for legitimacy to claim both expertise over its client group and differentiation from established professions. In a clinical context, the latter meant a struggle for autonomy from a medical speciality: psychiatry.
- The emergence of the profession has historical foundations beyond its relationship with the older dominant groups in the academy and clinic. In particular, wartime conditions and public policy structures (such as our health care system) were important. We have also noted the spur to the development of the profession that was provided by the vigorous popular psychology movement in Britain. To understand the profession in historical terms requires some understanding of these influences.

Some further reflections can be offered about our cultural legacy. The brief historic account above has missed out huge chunks of commentary about non-British influences on clinical psychology in an international context.

The content of clinical psychology's theory and practice is not uniform internationally. Whilst similarities exist across countries

and continents, each has its own national and cultural motif. For example, our account in this book emphasises quite a narrow range of influences before 1900. Apart from some temporary modelling on German academic pioneers, British empiricist philosophy and Galtonian eugenics (with its cue for the psychology of individual differences) have determined our professional orthodoxy. When we look elsewhere, we find a slightly more variegated picture.

When John Reisman was faced with writing a history of clinical psychology from a US perspective in the mid-1960s (Reisman, 1966), he mentioned a wide range of influences before 1900. These certainly included the British empiricists, who provided the philosophical soil for North American behaviourism to take root and flourish, but he also highlights the French influence in the work of Rousseau and Pinel. Murphy (1928), a US historian of psychology in the early twentieth century, pointed to other French influences: in particular, the work of Condillac, Charcot and Mesmer. From a North American perspective, it might also be significant that Reisman emphasises the political unrest which characterised France, Germany, Russia and his own country during the nineteenth century. Dramatic historical events (for example the war of independence, 'conquering' the western frontier and the consequent genocide of native people, civil war, and the abolition of slavery) were mirrored in North American human science, which has built larger and bolder theoretical structures than its British equivalent.

The internal boundary-breaking of the USA and its imperialist adventures abroad became cultural features which shaped its native psychology. By contrast Britain, with its peculiar island mentality, was a declining colonial power at the start of the twentieth century. British psychology and its applied clinical wing to some degree reflect the mood of this historical period. They have been conservative, empiricist, pragmatic, and incrementalist and have tended to eschew a commitment to theoretical systems building (a task left to others abroad). A number of examples reinforce this point. Although British empiricism may have been the philosophical source of the type of cognitive therapy practised recently in British clinical psychology, its theoretical rationale is located in American work. Even when developments were fairly a-theoretical or eclectic, the seminal *rationales* for clinical work originated in the USA. Cognitive-behaviour therapy (CBT) and rational emotive behaviour therapy (REBT) were instigated by the American psychiatrists Aaron Beck and Albert Ellis respectively. Clinical leadership in CBT innovations continues to be dominated by American psychologists (such as Marsha Linehan and Christine Padesky). It is true that the main instigator

of cognitive-analytic therapy (CAT) was a British general practitioner (Ryle, 1990). However, its theoretical roots were in American humanism (George Kelly's personal construct therapy), continental psychoanalysis and Russian neuropsychology.

While James Watson, B.F. Skinner and the American learning theorists developed the British empiricist principles (and indeed some of the physiological work of Hartley), as did Bechterev and Pavlov in pre-Revolutionary Russia, British clinical psychology has found itself reimporting philosophical premisses shaped elsewhere. Even the modest theoretical positions that have been championed (for example the methodological behaviourism underpinning British behaviour therapy in the late 1950s and early 1960s) were associated with intellectual émigrés (Hans Eysenck, Jack Rachman, Monte Shapiro and Victor Meyer). A consequence of our post-colonial, empiricist and pragmatic culture has been a relative absence of home-grown theoretical innovation. Our 'special relationship' with the USA in disciplinary terms has ensured that the North American academic culture has had a continuous influence on British professional practice and concerns. This reflects an enduring, if selective, intellectual reliance upon the grander scale and content of North American psychology.

Thus, the development of clinical psychology in Britain over the past hundred years can be understood in relation to a number of dynamics and factors. The knowledge base inherited from the longer history Eysenck alludes to, cited above, is important. However, the specific culture of Britain is also relevant – both to the empiricism that influenced the emerging profession, and the structural constraints that moulded it within the National Health Service. As will be clear in the rest of the book, the context of the profession contains both epistemological and organisational features that need to be understood as a whole system.

This chapter has introduced a number of threads of understanding about British clinical psychology. As an interest group it needs to be understood sociologically. As a culture with a contested range of ideas and practices it needs to be understood historically. As a form of applied human science its peculiarities need to be explored because professions that deal with other human beings are special and, within that group, those claiming expertise in human behaviour and experience are particularly special. These themes about the socio-historical nature of the profession will be explored further in the rest of the book, with attention to clinical psychologists as one professional group, amongst a few, of applied human scientists.

Note

¹ The Maudsley Hospital was and remains the main associate clinical base for the Institute of Psychiatry, a college of the University of London. For this reason, the hospital's name is sometimes used synonymously with that of the Institute.